

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13947

CERTIFICATE OF DEATH

13949

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> (rural) 04-1 d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Beach</u> Last <u>Beach</u>			4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>19 66</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-95</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>			
13. FATHER'S NAME <u>Daniel Hilliard</u>			14. MOTHER'S MAIDEN NAME <u>Tempest Paxton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-38-0398</u>		17. INFORMANT <u>Betty Eby</u> Address <u>Island Creek, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>725X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>chronic arthritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29, 1966</u> to <u>Oct. 31, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 30, 1966</u> , and that death occurred at <u>530A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Roberto de Villarreal</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>10-31-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Roberto de Villarreal, M.D.</u>			22d. ADDRESS <u>St. Leonard, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Port Republic, Calvert Co., Md.</u>				
24. FUNERAL DIRECTOR <u>A.A. Harkness, Port Republic, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13950

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Prince Fred Md.</i>				c. LENGTH OF STAY IN ID			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Calvert Co. H.</i>				e. STREET ADDRESS <i>041</i>			
3. NAME OF DECEASED (Type or print) <i>Shirley Lynn Blue</i>				4. DATE OF DEATH <i>10 8 1966</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/3/64</i>	
9. AGE (in years last birthday) <i>13 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Larry Gould</i>				14. MOTHER'S MAIDEN NAME <i>Shirley Kent</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Shirley Kent, Olivet Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5710 fash's infectious virus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Seemed better than when I saw her some</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot deep enroute to H</i>					
20c. TIME OF INJURY Month, Day, Year <i>12 10 10/8/66</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Olivet Calvert Md.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>H. C. [Signature]</i>				22. DATE SIGNED <i>10/8/66</i>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-11-66</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Eastern C.h.Cem</i>		23d. LOCATION (City, town or county) (State) <i>Olivet Cal. Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell</i> ADDRESS <i>Prince Fred-Md.</i>				25a. REC'D BY REGISTRAR <i>OCT 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Calvert					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Island Creek					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Island Creek Md				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) George Webster Bourne					4. DATE OF DEATH Month 10 Day 28 Year 1966				
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 - 3 -		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Bourne					14. MOTHER'S MAIDEN NAME Martha Keys				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 218-12-9279-A		17. INFORMANT Gloria Parker Address Island Creek-Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO (b) Chronic Rheumatoid arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 19 1966 , to Oct 28 1966 , that (I) (we) last saw the deceased alive on Oct 19 1966 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE R. J. O'Neil					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) R. J. O'Neil					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-30-66		23c. NAME OF CEMETERY OR CREMATORY Brooks C. Cem		23d. LOCATION (City, town or county) (State) Mutual Calvert Md.			
24. FUNERAL DIRECTOR ADDRESS Pinkney E. Sewell Prince Frederick-Md					25a. REC'D BY REGISTRAR DATE NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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George ...

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13950

CERTIFICATE OF DEATH

13952

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			c. LENGTH OF STAY IN 1b 7 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olive Middle Reed Last Bowen				4. DATE OF DEATH Month 10 Day 10 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-91		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Calvert County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jones				14. MOTHER'S MAIDEN NAME Elizabeth Wilkerson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216-18-5667		17. INFORMANT Address Elizabeth Stuart Chesapeake Beach, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial infarction DUE TO Cholesterol accumulation (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct. 3 , 19 66 , to Oct. 10 , 19 66 , that (I) (we) lost saw the deceased alive on Oct. 10 , 19 66 , and that death occurred at 7:00 PM , from causes and on the date stated above.							
22a. SIGNATURE George J. Weems				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 11, 1966	
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.				22d. ADDRESS Huntingtown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 13, 1966	23c. NAME OF CEMETERY OR CREMATORY Lower Marlboro Chr. Cem. Lower Marlboro Cal. Co. Md.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Hutchins Funeral Home Pivings Md				25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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NAME		LAST		FIRST		MIDDLE	
ADDRESS		CITY		STATE		ZIP	
TELEPHONE		CITY		STATE		ZIP	
OCCUPATION		CITY		STATE		ZIP	
EDUCATION		CITY		STATE		ZIP	
MARRIAGE		CITY		STATE		ZIP	
CHILDREN		CITY		STATE		ZIP	
MILITARY		CITY		STATE		ZIP	
REMARKS		CITY		STATE		ZIP	
SIGNATURE		CITY		STATE		ZIP	
DATE		CITY		STATE		ZIP	
INITIALS		CITY		STATE		ZIP	
FINGERPRINTS		CITY		STATE		ZIP	
PHOTOGRAPH		CITY		STATE		ZIP	
X-RAY		CITY		STATE		ZIP	
LABORATORY		CITY		STATE		ZIP	
TESTS		CITY		STATE		ZIP	
RESULTS		CITY		STATE		ZIP	
CONCLUSIONS		CITY		STATE		ZIP	
RECOMMENDATIONS		CITY		STATE		ZIP	
FOLLOW-UP		CITY		STATE		ZIP	
CONTACT		CITY		STATE		ZIP	
NOTES		CITY		STATE		ZIP	
ADDITIONAL INFORMATION		CITY		STATE		ZIP	
OTHER COMMENTS		CITY		STATE		ZIP	
REMARKS		CITY		STATE		ZIP	
SIGNATURE		CITY		STATE		ZIP	
DATE		CITY		STATE		ZIP	
INITIALS		CITY		STATE		ZIP	
FINGERPRINTS		CITY		STATE		ZIP	
PHOTOGRAPH		CITY		STATE		ZIP	
X-RAY		CITY		STATE		ZIP	
LABORATORY		CITY		STATE		ZIP	
TESTS		CITY		STATE		ZIP	
RESULTS		CITY		STATE		ZIP	
CONCLUSIONS		CITY		STATE		ZIP	
RECOMMENDATIONS		CITY		STATE		ZIP	
FOLLOW-UP		CITY		STATE		ZIP	
CONTACT		CITY		STATE		ZIP	
NOTES		CITY		STATE		ZIP	
ADDITIONAL INFORMATION		CITY		STATE		ZIP	
OTHER COMMENTS		CITY		STATE		ZIP	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13951

CERTIFICATE OF DEATH

13953

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 32 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS —			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Winfield Brooks				4. DATE OF DEATH Month October Day 22 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-20-77	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 04 Days 1		IF UNDER 24 HRS. Hours 1 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Winfield Brooks				14. MOTHER'S MAIDEN NAME Parker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-18-9847		17. INFORMANT Nancy Dolan - Solomons, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to coronary artery disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22/66 , 19 66 , to 10/22/66 , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7 M, from causes and on the date stated above.							
22a. SIGNATURE [Signature]				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. DeWitt Baker				22d. ADDRESS St. Leonard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Solomons Methodist Cem.		23d. LOCATION (City or Town) (County) (State) Solomons, Calvert, Md.	
24. FUNERAL DIRECTOR A.A. Henderson & Son - Port Republic, Md.				25a. REC'D BY REGISTRAR DATE OCT 25 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

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CHIEF OF POLICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body, and in any event, within 72 hours after death.

13952

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13954

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 46 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle Brown Last Brown		4. DATE OF DEATH Month October Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/94
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brown		14. MOTHER'S MAIDEN NAME Alice Coates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-26-4025	
17. INFORMANT Kizzie Jones - Daughter		Address Huntingtown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant DUE TO Caj Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 , to Oct 2 , 19 66 , that (I) (we) last saw the deceased alive on 19 and that death occurred at 7 M, from causes and on the date stated above.			
22a. SIGNATURE Roberto deVillarreal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Roberto deVillarreal		22d. ADDRESS St. Leonard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-4-66	23b. DATE THEREOF 10-4-66	23c. NAME OF CEMETERY OR CREMATORY Paterson C. Cem.	23d. LOCATION (City or Town) (County) (State) Huntingtown, Md
24. FUNERAL DIRECTOR Linkney E. Sewell Jr. Frederick, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 7 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13953

CERTIFICATE OF DEATH

13955

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Fred erick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Percy Middle Julius Last Hamilton		4. DATE OF DEATH Month October Day 29 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-92
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Julius Hamilton		14. MOTHER'S MAIDEN NAME Ella Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 214-12112A	
17. INFORMANT Guila G. Jones, Owings, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder DUE TO 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) c DUE TO Metastasis. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1966 , to Oct 29, 1966 , that (I) (we) last saw the deceased alive on 11 Nov. 1966 , and that death occurred at 7A-M , from causes and on the date stated above.			
22a. SIGNATURE Issam F. Damalouji		22b. DATE SIGNED Nov 1 1966	
22c. PHYSICIAN'S NAME (Type) Issam F. Damalouji		22d. ADDRESS Plum Point Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-2-66		23b. DATE THEREOF Coopers C. Cem	
23c. NAME OF CEMETERY OR CREMATORY Dunkirk Calvert Md		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Pinkney E. Sewell Prince Frederick-Md.		25. REC'D BY REGISTRAR NOV 1 1966	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13956									
1. PLACE OF DEATH e. COUNTY <i>Calvert</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Free Market</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dumfries</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>High</i> First <i>Elmer</i> Middle <i>Harris</i> Last			4. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>1966</i>						
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 13 1915</i>		9. AGE (In years last birthday) <i>51</i> yrs.		10. IF UNDER 1 YEAR Months <i>13</i> Days <i>15</i>		11. IF UNDER 24 HRS. Hours <i>15</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>High W. Harris</i>					14. MOTHER'S MAIDEN NAME <i>Evelene Harris</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>High W. Harris</i>		Address <i>Dumfries</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Accident</i> <i>9298</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fell over board, cold water</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Walked to car</i>						
20c. TIME OF INJURY Month, Day, Year <i>5:30 a.m. 10/23/66</i>			20d. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Free Market</i>		20f. (City or town) (County) (State) <i>Calvert MD</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H. W. Ward</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)					M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <i>10/23/66</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<i>Burial</i>			<i>10-27-66</i>		<i>St. Johns Church Cem.</i>				
24. FUNERAL DIRECTOR <i>Leroy E. Berry</i>					ADDRESS <i>Huntington</i>		REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
					DATE <i>OCT 25 1966</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>95 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olivet</u>				d. STREET ADDRESS <u>04-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nettie Johnson</u> First Middle Last						4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>5-24-87</u>		9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Thomas Grover</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Tall</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-07-8980</u>		17. INFORMANT Address <u>Mrs. Esther Tall, Olivet, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown occlusion</u> 4201 DUE TO (b) <u>an generalized arterial sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>66</u> , to <u>Oct 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> , 19 <u>66</u> , and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <u>William Johnson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 30 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. Johnson</u>						22d. ADDRESS <u>St. Thomas</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		23d. LOCATION (City, town or county) <u>Lady, Calvert Co., Md.</u>		(State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>A.A. Nedra & Son, Port Republic, Md</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>NOV 2 1966</u>						DATE <u>NOV 2 1966</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons Grove Park					c. LENGTH OF STAY IN 1b 11 1/2 days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital					d. STREET ADDRESS Solomons						
3. NAME OF DECEASED (Type or print) First Clifford Middle James Last Lusby					4. DATE OF DEATH Month 10 Day 24 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/87		9. AGE (In years last birthday) 79 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (County & State, or foreign country) Calvert Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William J. Lusby					14. MOTHER'S MAIDEN NAME Sewell Foster						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 219-16-0990A		17. INFORMANT Mrs. Etha Mae Jenkins, Staten Island, N. Y.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eurym 177X DUE TO Cay pro Tals Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-23-64 , 19 64 to 10-24-66 , 19 66 , that (I) (we) last saw the deceased alive on 10-24-1966 , and that death occurred at 10:20 M, from the causes and on the date stated above.											
22a. SIGNATURE G. J. Weems					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-25-66				
22c. PHYSICIAN'S NAME (Type) G. J. Weems					22d. ADDRESS Huntingtown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Solomons Methodist Cemetery			23d. LOCATION (City, town or county) (State) Solomons Calvert Co. Md.				
24. FUNERAL DIRECTOR A. A. Harkness & Son					ADDRESS Port Republic, Md.		25a. RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE OCT 27 1966											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Calvert Co. Hospital</i>		e. STREET ADDRESS <i>Sunderland 04-1</i>	
3. NAME OF DECEASED (Type or print) First <i>Marion</i> Middle <i>etta</i> Last <i>Wackall</i>		4. DATE OF DEATH Month <i>10</i> Day <i>13</i> Year <i>1966</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10/10/11</i>
9. AGE (in years last birthday) <i>55 yrs.</i>		IF UNDER 1 YEAR Months <i>3</i> Days <i>5</i> Hours <i>5</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Hardy Wackall</i>		14. MOTHER'S MAIDEN NAME <i>Rose Wackall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-381462</i>	
17. INFORMANT <i>Mable Hawkins-Dunkirk</i>		Address <i>Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 7824 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Began to cough and died before got to hospital</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <i>12:05 PM</i> <i>10/13/66</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Sunderland</i>		(County) <i>Calvert</i>	
(State) <i>Md</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>H W Wackall</i>		22. DATE SIGNED <i>10/13/66</i>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-16-66</i>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <i>Patuxent C. Cem</i>	23d. LOCATION (City, town or county) (State) <i>Patuxent Cal Co. Md</i>
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell</i>		25a. REC'D BY REGISTRAR <i>OCT 18 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

10255

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13958

CERTIFICATE OF DEATH

13959

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown (rural)</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		04/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>Need Estate</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>William</u> Last <u>Newland</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1908</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August William Newland Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Haumbach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-48-0635</u>		17. INFORMANT <u>Mrs. Gertrude Newland, Huntingtown</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive carcinoma of</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Larynx - with metastasis.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>—</u> , to <u>1966</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>10-1-1966</u> , and that death occurred at <u>10A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Issam F. Damalouji M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>—</u>		22b. DATE SIGNED <u>10/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Issam F. Damalouji M.D.</u>				22d. ADDRESS <u>Prince Frederick Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sat. Oct. 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Solomons Calvert Md.</u>	
24. FUNERAL DIRECTOR <u>A. A. Harkness & Son</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13959

13961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIRFORCE BASE</u> d. STREET ADDRESS <u>BOO. NAVAL AIR FACILITY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LT Frank Welch Smith Jr.</u> First Middle Last 4. DATE OF DEATH <u>10 14 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11/17/32</u> 9. AGE (In years last birthday) <u>33</u> yrs. IF FUNER 1 YEAR Months Days IF FUNER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>		11. BIRTHPLACE (State or foreign country) <u>DAVENPORT IOWA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK W SMITH SR.</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE MARIE BOBERICH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES ACTIVE DUTY</u>		16. SOCIAL SECURITY NO. <u>561-54-5510</u> 17. INFORMANT <u>NAVAL RECORDS ANDREWS AFB.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull & Internal injuries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8234</u> DUE TO (c) <u>Internal injuries</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Car accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Telephone pole got in his way</u>	
20c. TIME OF INJURY Month, Day, Year <u>10/14/66</u> Hour <u>8</u> a.m. <u>7</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>CSX 1495 #200</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Calvert Md</u> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>H. W. Ward</u>		22. DATE SIGNED <u>10/14/66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>INGLEWOOD PARK</u>		23d. LOCATION (City, town or county) (State) <u>LOS ANGELES CALIF.</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u> Address <u>1400 Chapin St NW Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> OATE <u>OCT 13 1966</u>	

19301

19301

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 11, 12 Film G382 11/15/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13962

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE BEACH				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gastonia			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 808 W. Airline Avenue			
3. NAME OF DECEASED (Type or print) First MAJORIE Middle Summey Last STROUPE				4. DATE OF DEATH Month October Day 27 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 6/10/1909	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ware Shoals, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jess William Summey				14. MOTHER'S MAIDEN NAME Willie Reid			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Carothers F. Hume - Gastonia, N.C.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.				22. DATE SIGNED October 28, 1966			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/66		23c. NAME OF CEMETERY OR CREMATORY Gaston Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Gastonia, N.C.	
24. FUNERAL DIRECTOR James M. Fields 4481 Bonnie Blue Rd.				25a. REC'D BY REGISTRAR DATE NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13840

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13963

1. PLACE OF DEATH a. COUNTY <u>Calvert County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN ID <u>04/1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Prince Frederick</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Wallace Jr</u>		4. DATE OF DEATH Month Day Year <u>10 9 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-51</u>
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Calvert County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Edward Wallace, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Orlye Jacks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Dr. James Edward Wallace Sr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 9298 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>POND</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary United Church</u>		23d. LOCATION (City, town or county) (State) <u>Sunderland Md.</u>	
24. FUNERAL DIRECTOR <u>Leroy E. Berry-Huntingtown</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>OCT 11 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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